MEDI-CAL STATUS REPORT

ATTENTION: STATE LAW NOW REQUIRES YOU TO COMPLETE A MIDYEAR MEDI-CAL STATUS REPORT.

YOU MUST RETURN THIS REPORT BY: _____ TO KEEP YOUR MEDI-CAL.

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____

If the only persons in your family receiving Medi-Cal are aged, blind, or disabled, or individuals under the age of 21; and/or pregnant women whose eligibility is limited to pregnancy-only benefits, **you do not have to complete and return this report.**

If you need help in completing this report, call your worker whose name and telephone number are listed above.

SECTION 1—NO CHANGES TO REPORT

If in the last **six months** you have not had any changes to the items listed in Section 2, check this box. ☐ **NO CHANGES**

- Do not fill out Section 2. Go directly to Section 3.
- **Sign** and **date** this report in Section 3 on the back of this page. You must return the report in the enclosed preaddressed postage-paid envelope by the date on the top of this page.

CHANGES TO REPORT

If in the last **six months** you have changes to report, you must complete Section 2 and Section 3.

- In Section 2, for each item where you had a change, mark the "Yes" box and explain the change.
- Do not send any documentation with this form.
- Go to Section 3, **sign** and **date** this report. You must return the report in the enclosed preaddressed postage-paid envelope by the date on the top of this page.

REMEMBER, YOU MUST SIGN THE BACK.

CONTINUE ON REVERSE SIDE.

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DO NOT SEND ANY DOCUMENTATION WITH THIS FORM

SECTION 2 **Check "Yes" for all changes and explain.**

Income Changes ❒ **Yes**

Did your household's income decrease or increase? Did someone in your household over the age of 14 start a new job or quit their job? For example: hourly wage, child support received, unemployment benefits, tips, government benefits, tax refunds, gifts, etc. **Please explain:**

Expenses Paid Changes ❒ **Yes**

Have you had any changes in the amounts you pay for child care, health insurance, court-ordered child support, or educational expenses? **Please explain:**

Living Situation Changes ❒ **Yes**

Did someone move in or out of your household (for example, child was born, household member got married, etc.)? If so, do they want Medi-Cal? ❒ Yes ❒ No **Please explain:**

Other Changes ❒ **Yes**

Did someone in your household have a change in the amount of property they have (for example, money in bank accounts, vehicles, real estate, etc.) their immigration status, or other health insurance benefits? **Please explain:**

Disabled ❒ **Yes**

Has anyone in your household become disabled?
If yes, who?

Pregnant ❒ **Yes**

Has anyone in your household become pregnant?
If yes, who?
If yes, what is the expected due date?

SECTION 3 **MUST BE COMPLETED**

Signature and Certification

I understand that I must report all changes in income, property, and/or other changes to the county. I declare under penalty of perjury that all information provided above is true and correct.

Signature	Phone ( )	Date
Witness signature (if person signed with a mark)	Phone ( )	Date
Signature of person acting for beneficiary	Relationship to beneficiary	Date